**Minutes of Meeting**

**Tertiary Care Advisory Committee**

**Date: 20 March 2007 Time: 1:00 PM**

**Location: Conference Room 401**

**ATTENDANCE:**

**Council: Present: Gregory Allen, DO, Catherine Graziano, RN. PhD, Sam Havens, Robert S.L. Kinder M.D., Gus Manocchia, MD, Ed Quinlan, and Robert J. Quigley, D C (Chair)**

**Not Present: John Flynn, and Joan Kwiatkowski (excused), and Mark Reynolds**

**Staff: Valentina D. Adamova, Jay Beuchner, Michael Dexter, Linda TetuMouradjian, RN, Donald C. Williams and Harvey Zimmerman**

**Public: Attached**

**1. Call to Order and Approval of Minutes**

**The meeting was called to order at 1:00 PM. The Chairman noted that conflict of interest forms are available to any member who may have a conflict. The minutes of the 13 February 2007 meeting of the Tertiary Care Advisory Committee were approved as submitted. The**

**Chairman requested a motion for the extension of time for the availability of minutes pursuant to the Open Meetings Act. A motion was made, seconded and passed by a vote of seven in favor and none opposed that the availability of the minutes for this meeting be extended beyond the time frame provided for under the Open Meetings Act. Those members voting in favor of the motion were: Allen, Graziano, Havens, Kinder Manocchia, Quinlan, and Quigley.**

**2. General Order of Business**

**The chairman distributed letters from Roger Williams Medical Center (RWMC) and Landmark Hospital to the committee. He commented that Harvey Zimmerman was present to answer questions and asked Jay Buechner to present the results of a report on hospital volume, transfers, and in–hospital mortality for cancer related esophageal and pancreatic resection procedures. The report was a revision of previously released data prepared for the TCAC. Based on input from the hospital administrators and surgeons who presented at the last meeting, additional data was included. Lifespan and Roger Williams Medical Center, provided corrections and South County Hospital validated their data. He also presented a report on facility specific in-hospital mortality rates for the period of 2001-2005 (calendar years) by facility (physician data was included from January 2005 forward when it became available).**

**A member asked how the Department collects these types of data. Dr.**

**Buechner explained that the Department received quarterly batches of information from all acute care hospitals. Another member asked what the definition of transfer meant in the report. Dr. Buechner explained that transfers occurred after a surgical procedure was performed. A member asked the group if referrals made by United to providers in Minnesota were related to quality or outcome issues. Dr. Lui stated that the referrals were related to bone marrow transplants that could not be performed in the state.**

**Ed Quinlan asked if the Department would accept the data supplied by the hospitals used to update the reports. Dr. Buechner responded by saying that there were differences in the data collected by the Department compared with the hospital data and that the Department needed to understand the validity of their own data. He added that the Department would follow-up with the hospitals to reconcile issues with the data.**

**The Chairman invited both Dr. Cody and Dr. Luis to provide their opinions on the quality, volume and outcome issues being discussed. Dr. Coady suggested that data should be collected at the level of the surgeon performing the procedure as well as at the facility level. He also suggested that the committee review alternative literature focusing on patient outcomes and long term survival as it relates to both procedures under discussion. He made several points related to the high quality of care patients receive at Landmark Medical Center, recruiting and training of surgeons that perform these procedures,**

**the ability to provide these types of surgical procedures to service the local population and the effective quality assurance component built into the system to achieve quality patient outcomes. Oversight in the hospital's Department of Surgery consisted of monthly morbidity and mortality peer review of cases and review of lower volume procedures with the potential for increased mortality (pancreatic and esophageal) by the Internal Surgical Case Committee.**

**Dr. Coady pointed out that if the committee restricted numbers of procedures to allow only high volume institutions to provide this level of care it would be harmful for Landmark Medical Center. He stated it would hurt the hospital's ability to recruit and maintain surgeons who elect to perform these types of procedures in a community like Woonsocket. Currently Landmark is able to offer patients a full spectrum of both cardiac and oncology services. He emphasized that centers that produce the higher numbers of surgical procedures may not produce the quality. Several times he recommended that the Department should collect data on these types of procedures by surgeon and by institution.**

**A member asked what the Department's role was in all of this? Was it just to collect statistics or to review quality programs? Dr. Buechner explained that in this particular function it was to establish regulations governing tertiary care. Don Williams further explained that quality oversight was each hospital's responsibility and that**

**Department regulations require hospitals to establish internal quality assurance committees to address these issues. Additionally, regulation of the aforementioned activity is through a complaint process once notified the Department will review the complaint and investigate if warranted.**

**The Chairman stated that the committee was not mandated to make decisions on determining standards for these two procedures. He asked if the committee could continue to follow-up on mortality associated with the procedures in these institutions for the next couple of years. The goal would be to revisit the issue at a later time. Don Williams answered affirmatively and stated that the statute was permissive. Additionally, in regard to making recommendations to the Director if the issues under discussion were not clear or of sufficient magnitude the committee could also communicate that kind of information to the Department.**

**Michael Dexter explained that recently the Department had restrictions on angioplasty, which required hospitals to have on-site open-heart surgical back up. Kent Hospital requested a variance and the request was granted. Even if this committee recommends minimum volumes for these procedures and the Department establishes them, he noted that any hospital has the right to request a variance. They can present individual cases to the Department for a variance against small numbers of procedures. This would address Roger Williams Hospital's Landmark's situation where each has the**

**surgeons, infrastructure, and ICU but are restricted by small numbers.**

**In response to a question, Don Williams stated that there was a requirement in the law for hospitals to report unusual events (unexpected deaths). A nurse in the Department reviews the report and based on the findings a decision is made as to whether it needs further investigation.**

**The Chairman asked if the Department finds out that there are increased number of incidences on a tertiary care service could the Department remove the license from a hospital or remove the service? Don Williams answered that there are very specific requirements in the rules and regulations primarily to structure a process to address this issue. If the problem falls outside a particular range, regulatory action can be taken.**

**A member asked Dr. Coady his opinion about using the hospital mortality rate as a proxy for quality. He also asked him what he thought was an acceptable percentage for each procedure. Dr. Coady replied there are benchmarks, national standards in the literature that are different for each procedure. He gave an example for cardiac surgery that includes post surgical patient follow-up for four weeks to check on pulse, blood pressure, medications and healing from the surgical incision site.**

**Dr. Monoptti stated that a patient's long-term survival is determined by how the medical system responds to the patient. He went on to say that oncology is a rapidly evolving field; outcomes are dependent on how patients are dealt with as a whole, that numbers (data) do not reflect the rapid changes in the field and just looking at numbers is following a narrow path. He commented that the American Board of Surgery and quarterly internal reviews vigorously set quality standards of surgery. Although people who perform these procedures are small in number, they are well trained.**

**Sam Havens commented that the committee's responsibility was to focus on volume and quality issues not the broader view of economic impact and its effect especially as it relates to long-term follow-up of uninsured patients. He said that there is no question that looking at long-term outcomes would be better but the cost of health insurance has a lot to do with long-term support of patients. The Chairman stated that whatever the impact of the spread of more procedures performed in more hospitals has on the economic system, it was outside of the committee's purview. Even if the committee chooses not to select these two procedures for making recommendations on volume and quality, the subject of economic impact can't be addressed. He stated the committee could recommend some tracking standards that would require long-term follow-up. Don Williams said the committee could always recommend further study of an issue to the Director.**

**The Chairman introduced Dr. Lui from Roger Williams Hospital. Dr. Lui stated that if you are going after a specific line of health care delivery, you've proven excellence in that line to some degree if you can show yourself to be cost and outcome efficient. He also stated that RWMC was the only hospital in the state that publishes their data, due to the fact that they are an academic center. RWMC has 1/14th of the number of surgeons trained in this country, which was a tremendous asset. Additionally, it was rare to be able to get those surgeons to stay in the state due to payer mix and other issues. He noted that RWMC has been able to recruit and maintain 4 surgical oncologists to their staff that they share with other institutions in the state. He stated that what that means is it raises the bar, these surgeons can go to a national meeting such as the American Society of Clinical Oncology (the premier organization for cancer care in the US) and present data to show that out of 356 esophageal resections performed, the 30 day peri-operative mortality rate was 2%.**

**Dr. Lui said the situation was somewhat clouded due to the fact that RWMC surgeons operate in other institutions throughout the state. For example Dr. Wanebo operates at RWMC and Landmark Medical Center and another doctor operates at RWMC and is applying for privileges at Kent Hospital. He stated that we are trying to serve people where they live, noting Mr. Zimmerman's statement that people would rather get local treatment even if the care were worse than travel to a tertiary care center. He said he suspected that in rural Iowa at a small hospital there weren't many choices especially as it**

**relates to surgical oncologists, and that most operations in rural communities are probably performed by general surgeons whose 30-day mortality rate would be 10% instead of 4%.**

**Dr Lui stated because we are an urban center with one of highest population densities in the US when talking about small hospitals and large hospitals there is sort of an artificial distinction. He thought surgeons should be held accountable for a low mortality rate and that the Department should track outcomes by surgeons and hospitals. Additionally, the focus should be on outcomes because it reflects the kind of judgment exercised to select patients for surgery. He also suggested the reason for the discrepancy with the numbers of procedures reported to the Department and the numbers recently provided by the hospitals was due to a diagnosis coding issue. He added that the cancer registry is another source available to find information on these procedures.**

**Upon questioning, Dr. Coady noted that it might take years to have a sufficient amount of cases to draw conclusions. He also recommended collecting data on mortality rates in the acute phase as well as 30 days post surgery. He said hospitals should report morbidity and mortality to the Department by surgeon and by facility.**

**The Chairman asked the physicians, if surgeons with multiple competencies were restricted by hospitals to perform certain procedures (if you isolated their practice to one hospital), would that**

**affect the ability to recruit and maintain surgeons. Dr. Lui and the other surgeons said that it would. The Chairman asked what relationship does the surgical team have in this. Dr. Monoptti replied that it was very important.**

**The Chairman requested guidance from the committee for to determine next steps to be taken. Ed. Quinlan commented that the original charge established early on to the committee was to examine and consider the wisdom of establishing volume related standards for these services. He further stated that the committee was not charged with establishing them but to examine the wisdom. The Chairman replied that if the committee decided to establish standards they would.**

**Michael Dexter stated that he did not recall that being the charge of the committee. He asked the committee was that one of Dr.'s Gifford's charges or did that idea originate from the members. Ed Quinlan agreed with Michael Dexter's perception that it was the committee's idea. He also stated the he wanted to make sure he understood and that the committee members were all operating on the same belief that the charge given to the committee was to examine the need or the ability or the wisdom to establish standards. He stated it might be helpful if Dr. Gifford addressed the committee on what his thinking was that triggered this entire process. Additionally, he said that Dr. Gifford was examining the creation of a surgeon registry and that the committee may want hear his thinking about that issue.**

**One of the members suggested that it might be a mistake to do a straw poll or consensus at the meeting and that the issues raised at this meeting should be discussed at the next meeting prior to a vote for a recommendation. Sam Haven raised concerns regarding the economic impact the committee's decisions would have on increasing costs of health insurance.**

**Adjournment**

**The next meeting of the TCAC will be held on April 17, 2007 at 1:00 PM in Room 401. There being no further business the meeting was adjourned at 2:00 PM.**

**Respectfully submitted,**

**Linda M. Tetu-Mouradjian, RN**